Standard Form for Presentation of Loss and Damage Claims

Name of person filing claim:	Name of Carrier **H&W TRUCKING CO., INC.**	DATE
Name and address of Claimant	Address **P.O.BOX 1545**	**Trip Number**
	City, State, Zip **MOUNT AIRY, N.C. 27030**	**Claim Number**
City, State, Zip	**P# (800) 334-9181 F# (336)789-7973** **Susan Thomas /** **sthomas@hwtrucking.com**	**H&W Pro Number**

This claim for $_____is made against the Carrier named above by_____
for☐loss☐ damage in connection with the following described shipments of paid Freight Bill #_____

Name and address of Consignor(Shipper)	Final Destination-Name and address of Consignee(whom shipped to)
Shipped From City,State,Zip	Carrier issuing BL
Shipped To : City,State,Zip	Date of B/L
If shipment reconsigned enroute, state particulars	

DETAILED STATEMENT SHOWING HOW AMOUNT CLAIM IS DETERMINED.

(Number and description of articles, nature and extent of loss or damage, invoice price of articles, amount of claim,etc)
SHOW ALL DISCOUNTS AND ALLOWANCES

****ITEM NUMBER & DESCRIPTION OF DAMAGE:**

TOTAL DOLLAR AMOUNT CLAIMED	

IN ADDITION TO THE INFORMATION GIVEN ABOVE, THE FOLLOWING DOCUMENTS ARE SUBMITTED IN SUPPORT OF THIS CLAIM

(** REQUIRED)

( ) Original bill of lading, if not previously surrendered to carrier
( ) Original paid freight (expense) bill.
( ) ****Copy of Original mfg. invoice**
( ) ****Photos of damage**

( ) Concealed loss or damage form from:
( ) Shipper ( ) Carrier ( ) Consignee
( ) Other particulars obtainable in proof of loss or damage.

Explain the absence of any document called for in this claim._____
_____

WHEN FOR ANY REASON, THE ORIGINAL PAID FREIGHT BILL OR BILL OF LADING IS NOT PROVIDED, CLAIMANT MUST INDEMNIFY CARRIER OR CARRIERS AGAINST DUPLICATE CLAIMS SUPPORTED BY ORIGINAL DOCUMENTS

INDEMNITY AGREEMENT

When the original bill of lading and/or freight bill is not submitted, or is not available for submission, but copies of the original are submitted in support of the claim described above, the claimant agrees to indemnify and hold harmless the carrier receiving this claim, named above, and any participating carriers, and will pay to the carrier or any participating carrier all losses, costs, damages, counsel fees or any other expenses it (the carrier) may incur resulting from all lawful subsequent duplicate claims arising out of the same shipment which may be filed and supported by the original documents.

Foregoing statement of fact is hereby certified as correct.

_____
Name of Claimant

_____
Date

_____
Street Address

_____
(Signature of Claimant)**

_____
City, State, Zip Code